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No. 06-324

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In the Supreme Court of the United States

BLUE CROSS & BLUE SHIELD OF MICHIGAN,
Petitioner,

v.

MICHAEL A. GENORD, M.D.; JOHN R. SANBORN, M.D.; PAULA M. FISHBAUGH, M.D.; ANDREA L. SCHILLER, M.D.; MARK D. DYKOWSKI, M.D.; JOHN E. ECKELE, M.D.; BETTY S. CHU, M.D., on behalf of themselves and all others similarly situated,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF IN OPPOSITION

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COUNTER-STATEMENT OF THE QUESTION PRESENTED

The district court held that Respondents' claim that Petitioner violated the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. 1961, *et seq.*, is not reverse-preempted by the McCarran-Ferguson Act. In affirming the district court's decision, the Sixth Circuit followed this Court's holding in *United States Department of Treasury v. Fabe,* 508 U.S. 491 (1993), that a state statute is enacted for the purpose of regulating insurance only to the extent that it furthers the interests of policyholders. Did the Sixth Circuit properly conclude that because Respondents' claim involves providers — rather than policyholders — it is not reverse-preempted by the McCarran-Ferguson Act?

PARTIES TO THE PROCEEDINGS AND RULE 29.6 STATEMENT

Respondents are individuals. They are not affiliated with any publicly-traded corporation.

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BRIEF IN OPPOSITION

SUMMARY OF REASONS TO DENY THE PETITION

"A petition for a writ of certiorari will be granted only for compelling reasons." Sup. Ct. Rule 10. Blue Cross Blue Shield of Michigan ("BCBSM") has failed to demonstrate that compelling reasons justify granting its petition in two respects. First, the Sixth Circuit's decision — that a group of medical providers' RICO claim is not exempt from preemption because it does not implicate policyholders' interests — does not conflict with this Court's decision in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993). Nor, does it conflict with a decision from any circuit. In *Fabe*, this Court held that to the extent that a state law regulates the relationship between an insurance company and its creditors, it does not regulate the business of insurance. The Sixth Circuit recognized that Respondents are medical providers, whose RICO claim is not linked to policyholders' interests and properly held that the McCarran-Ferguson Act does not bar Respondents' claim. This holding is in accordance with *Fabe* and with all other federal-court decisions that have addressed this issue.

Second, assuming, *arguendo,* that Respondents' RICO claim does involve policyholders' interests, it does not invalidate, impair, or supersede the Michigan Nonprofit Act. This Court already put this issue to rest in *Humana, Inc. v Forsyth,* 525 U.S. 299 (1999). In *Humana*, this Court held that policyholders' RICO claims against its insurance company survive, despite a state statute enacted for the purpose of regulating the business of insurance, because those claims did not invalidate, impair or supersede the state statute.

The facts in this case are more compelling than in *Humana* — Respondents are providers, not policyholders, and BCBSM is not an insurance company. BCBSM cannot demonstrate — and has not alleged in its Petition – that applying RICO in this case will impair the Nonprofit Act. Accordingly, compelling reasons for reviewing this case in this Court do not exist. BCBSM's Petition should be denied.

STATEMENT OF THE CASE

A. Respondents' RICO Claims.

Respondent Michael Genord, M.D., and six other physicians ("Respondents"), filed a complaint against Petitioner BCBSM alleging, among other things, violations of the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. 1961, *et seq*. Respondents assert that BCBSM failed to pay or delayed in paying legitimate claims for certain gynecological services. Respondents brought this lawsuit as a putative class action on behalf of more than 5,000 Michigan physicians providing gynecological services.

In 2002, BCBSM changed its billing codes for some gynecological services. Although Respondents complied with BCBSM's instructions on using the new codes, BCBSM routinely denied legitimate claims on false grounds, delayed payment unjustifiably, and made the claims process so daunting that some claims were abandoned. Even after Respondents verified that they were using the correct codes and resubmitted the legitimate claims, BCBSM improperly denied them.

Federal subject matter jurisdiction was based on the RICO claim.[1] BCBSM moved to dismiss for lack of subject matter jurisdiction, claiming that the RICO claim was barred by the McCarran-Ferguson Act, 15 U.S.C. § 1012. (R. 13, BCBSM's Motion to Dismiss Plaintiffs' First Amended Complaint and Brief).

B. The District Court Denied BCBSM's Motion To Dismiss Respondents' RICO Claim.

In its July 29, 2004, opinion and order, the district court held that Respondents' RICO claim was not reverse preempted by the McCarran-Ferguson Act. It held that the Nonprofit Act was not enacted for the purpose of regulating the business of insurance. (R.36, Opinion and Order Granting in Part and Denying in Part BCBSM's Motion to Dismiss, p. 7). The court relied both on the plain language of the Nonprofit Act,[2] which "itself does not indicate that it has anything to do with regulating the business of insurance," and on Michigan state-court decisions that have distinguished an insurance company from a healthcare corporation under the Nonprofit Act.[3] *Id.* (p. 8-9 of the Order).

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[1] Plaintiffs also brought state-law claims for breach of contract; violation of the Michigan Insurance Code, M.C.L. § 500.22006; and unjust enrichment. The district court granted BCBSM's motion to dismiss the count alleging violation of the Michigan Insurance Code. (R. 36, Opinion and Order Granting in Part and Denying in Part BCBSM's Motion to Dismiss).

[2] M.C.L. § 550.1102; M.C.L. § 550.1201; M.C.L. § 550.1202.

[3] The court relied on the following authorities for that proposition: Blue Cross Blue Shield of Michigan v Comm'r of Ins., 179 Mich App 246 (1989); Opinion of Michigan Attorney General, No. 7115.

The court also held that the type of conduct at issue in this case does not encompass the "business of insurance" within the meaning of the McCarran-Ferguson Act. *Id.* (p. 9 of the Order). The court relied on *Fabe*, *supra*, which held that a state statute is intended to regulate the business of insurance only to the extent that it protects the interests of policyholders. Because the claim in this case relates to creditors — not policyholders — the district court held that it did not involve the "business of insurance."

C. The Sixth Circuit Affirmed.

The district court granted BCBSM's request for certification of the issue for interlocutory appeal and the Sixth Circuit granted BCBSM's Petition for permission to appeal. In a published opinion, 440 F.3d 802, the Sixth Circuit affirmed the district court. In doing so, the Sixth Circuit relied on *Fabe* in recognizing that Respondents' claims fail to implicate policyholders' interests:

> Blue Cross fails to explain how the Health Care Act's regulation of the billing-code invoicing arrangement with health care providers furthers the interests of the policyholders. Contrary to Blue Cross's argument, this is not a case like *Fabe* where the state law requires the insurance company to pay the claims of the *policyholders* (a true case of "actual performance" of an insurance contract). The claims in dispute here are those of the medical providers, not the policyholders. . . . [T]he policyholders are unconcerned with the reimbursement arrangements between Blue Cross and the doctors so long as they receive medical

> treatment as contemplated by their agreement with Blue Cross.

440 F.3d at 808 (emphasis in original). As such, the Sixth Circuit concluded that the McCarran-Ferguson Act did not apply to Respondents' RICO claim.

REASONS FOR DENYING THE PETITION

I. THE SIXTH CIRCUIT'S DECISION DOES NOT CONFLICT WITH THIS COURT'S DECISION IN *FABE* OR WITH A DECISION FROM OTHER CIRCUITS.

BCBSM's argument that the Sixth Circuit's decision somehow conflicts with a decision from this Court and with decisions from other circuits ignores the narrow set of facts involved in this case. This case, involves nothing more than a group of Michigan medical providers who seek payment for properly submitted claims according to their reimbu. ement arrangements with BCBSM. BCBSM attempts to make this case bigger, by arguing that the Sixth Circuit's decision contravenes this Court's decision in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993). This argument fails to recognize this Court's central holding in *Fabe* that to the extent that a state law regulates the relationship between an insurance company and "creditors" other than policyholders, it does not regulate the business of insurance. *Id.* at 508.

In interpreting *Fabe*, federal courts have recognized that the relationship between medical providers — such as Respondents — and insurers seldom involve policyholders' interests. For instance, a federal court in Florida, when deciding a case very similar to this one offered the following guidance:

> Nothing in *Fabe*, however, suggests that the [McCarran-Ferguson] Act sweeps within its scope all laws that affect insurance companies. Indeed, the Supreme Court in *Fabe* supported the interpretation of the "business of insurance" as focusing on the relationship between the insurance company and the policy holder. Here, the Plaintiffs' relationship to the insurer is ancillary to the actual insurance contract itself. The contracts of insurance were between Defendants and the insureds, not between Defendants and the individual providers (service agreements). Accordingly, the Court finds that the relationship between insurers and providers falls outside the "business of insurance" and thus the [McCarran-Ferguson] Act does not pose a preemption issue.

In Re: Managed Care Litigation, 298 F. Supp. 2d 1259, 1285 (S.D. Fla. 2003).

Respondents are in the same position as the providers in *Managed Care*. Their RICO claim challenges BCBSM's fraudulent denial of proper claims in contravention of its reimbursement arrangement with doctors. (R. 11, Plaintiffs' First Amended Complaint). Any effects that Respondents' claim based on these arrangements has on policyholders are "too tenuous" to justify application of the McCarran-Ferguson Act to this case. *Fabe*, 508 U.S. at 509.

BCBSM attempts to connect Respondents' RICO claim and the interests of policyholders by arguing that the reimbursement arrangements impact the premiums that policyholders pay and the number of doctors and hospitals

available to them. According to BCBSM, these "arrangements do this by establishing a comprehensive network of providers who have agreed to provide medical services to BCBSM's policyholders under regulated contract provisions." Petition at 15. But this Court in *Fabe* disapproved of the very argument BCBSM makes, explaining that "such indirect effects are [not] sufficient for a state law to avoid pre-emption under the McCarran-Ferguson Act." 508 U.S. at 508-509 (citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 217 (1979)).

BCBSM ignores this teaching from *Fabe* and instead focuses its Petition largely on the fact that the Sixth Circuit analyzed this case within the framework set forth by this Court in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). Although BCBSM asserts that this is "a narrow, anti-trust-based analysis that has no place in determining whether a state insurance law should be protected from preemption," Petition at 5, this Court in *Fabe* expressly relied on *Pireno*. As explained by the Ninth Circuit in *Merchants Home Delivery Serv. v. Finked B. Hall & Co.*, 50 F.3d 1486, 1490 (9th Cir. 1995):

> In *Fabe*, the Supreme Court actually applied [*Pireno*], emphasizing that the acts involved there affected the transfer or spreading of risk. On the other hand . . . . the Court held the business of insurance was to be defined more broadly outside the antitrust area. This is a matter of degree, however, rather than a wholesale change in the inquiry.

Id. (citing *Fabe*, *supra*).

Furthermore, regardless of the framework within which the Sixth Circuit reached its decision, it appropriately recognized that Respondents' claim has no connection to policyholders. It involves only BCBSM's failure to pay claims to medical providers:

> Blue Cross fails to explain how the Health Care Act's regulation of the billing-code invoicing arrangement with health care providers furthers the interests of the policyholders. Contrary to Blue Cross's argument, this is not a case like *Fabe* where the state law requires the insurance company to pay the claims of the *policyholders* (a true case of "actual performance of an insurance contract). The claims in dispute here are those of the medical providers, not the policyholders.

440 F.3d at 808 (emphasis in original).

This holding is not only in accordance with *Fabe*, it is also in line with decisions from other circuits. BCBS unsuccessfully attempts to manufacture a conflict between this case and a Fourth Circuit case, *American Chiropractic Association v. Trigon Healthcare, Inc.*, 367 F.3d 212 (4th Cir. 2004). *Trigon Healthcare* involved an insurance company's refusal to cover chiropractic services due to anti-chiropractic bias. The result directly impacted policyholders because chiropractic services were not covered and a judicially-imposed coverage would directly change the underwriting equation.

The result of BCBSM's failure to pay in this case is vastly different. Unlike in *Trigon Healthcare*, Respondents — not policyholders — bear the brunt of BCBSM's failure to pay claims. As far as policyholders are concerned, they still receive Respondents' services under the same conditions, regardless of whether BCBS reimburses the providers for their services. Again, under such circumstances, "policyholders are basically unconcerned with arrangements made between [BCBS] and participating [physicians]." *Fabe*, 508 U.S. at 503.

This case also differs from other cases cited by BCBS, none of which involve an insurer's relationship with its providers. *See, e.g., Ambrose v. Blue Cross & Blue Shield of Virginia*, 891 F. Supp. 1153 (E.D. Va. 1995), *aff'd* 95 F.3d 41 (4th Cir. 1996) (involving a statute regulating the performance of a contract between the insured and its policyholders); *Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185 (3d Cir. 1998) (same); *Stephens v. American Int'l. Co.*, 66 F.3d 41 (2d Cir. 1995) (same); *Ruthardt v. United States*, 303 F.3d 375 (1st Cir. 2002) (involving a statute assuring repayment to policyholders); *Davister Corp. v. United Republic Life Ins. Co.*, 152 F.3d 1277 (10th Cir. 1998) (involving a statute that consolidated all claims, including those of policyholders, against a liquidating insurer); *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486 (9th Cir. 1995) (involving statutes regulating the setting and collection of premiums).[4]

[4] BCBS also relies on *Greene v. United States*, 440 F.3d 1304 (Fed. Cir. 2006), which fails to support its position. In *Greene*, the court held that the state statute at issue did not protect policyholders' interests and was, therefore, not enacted for the purpose of regulating the business of insurance. BCBS also cites two other cases, *Blackfeet Nat'l. Bank v. Nelson*, 171 F.3d 1237 (11th Cir. 1999); and *Doe v. Norwest Bank Minnesota, N.A.*, 107

These cases fail to support BCBSM's claim that the Sixth Circuit's decision somehow conflict with this Court's decision in *Fabe* or with decisions from other circuits. Again — this case is merely a vehicle for allowing a group of medical providers who are owed reimbursement from BCBS from properly submitted claims to receive payment. As the Sixth Circuit correctly held, it has no impact on policyholders. This holding is in line with *Fabe* and with all other decisions from other circuits involving the relationship between providers and insurers. Accordingly, BCBS has not carried its burden of demonstrating "compelling reasons" for its Petition to be granted, Sup. Ct. Rule 10, and its Petition should be denied.

II. RESOLUTION OF THE QUESTION PRESENTED WILL NOT BAR RESPONDENTS' RICO CLAIM BECAUSE, AS THIS COURT ALREADY ADDRESSED IN *HUMANA, INC. V. FORSYTH*, RICO DOES NOT INVALIDATE, IMPAIR, OR SUPERSEDE THE NONPROFIT ACT.

Assuming, *arguendo*, that this case implicates policyholders' interests, Respondents' RICO claim does not invalidate, impair, or supersede the Nonprofit Act. This issue was put to rest in *Humana, Inc. v. Forsyth*, 525 US 299 (1999). In *Humana*, the plaintiffs, a group of insureds, sued Humana Insurance, admittedly an insurance company, for allegedly defrauding them in a RICO scheme. Humana asserted that RICO impermissibly impaired the state insurance laws in violation of the McCarran-Ferguson Act. The Court disagreed and held as follows:

F.3d 1297 (8th Cir. 1997). These cases are inapposite because they deal with the issue of whether certain banking practices constitute the business of insurance.

> We hold that RICO can be applied in this case in harmony with the State's regulation. When federal law is applied in aid of enhancement of state regulation, and does not frustrate any declared state policy or disturb the State's administrative regime, the McCarran-Ferguson Act does not bar the federal action.

Id. at 303.

Applying *Humana* to this case yields the same result. Like the Nevada law in *Humana*, the Michigan Nonprofit Act allows the Insurance Commissioner to issue charges if there is reason to believe the Act is being violated. 525 U.S. at 311-12; M.C.L. 550.1402(8). Both Nevada and Michigan allow a private right of action for fraud. 525 U.S. at 312; M.C.L. 550.1402(1)(a), (d), (f), (l) (it is a prohibited act to misrepresent pertinent facts relating to coverage, refuse to pay a claim without conducting a reasonable investigation, fail to attempt in good faith to make a prompt payment on a claim, or to promptly provide a reasonable explanation for denial of a claim); M.C.L. 550.1402(8) ("This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section," which includes '1402(1)(a), (d), (f) and (l)).

Insurers in Nevada and BCBS in Michigan have each relied on this right to bring actions against those they believe defrauded them. *See e.g., BCBS v. Folkema*, 174 Mich. App. 476 (1988) (suit claiming fraud against provider). The same right is enjoyed by those on the other side of the equation, i.e. the providers. Finally, neither Nevada in *Humana*, nor Michigan in this case, has filed any papers with the court claiming "that application of RICO to the alleged

conduct would frustrate any state policy, or interfere with the State's administrative regime." 525 U.S. at 313.

BCBSM's Petition fails to address the impact of *Humana* on this case. Rather, it focuses entirely on the question of whether the Nonprofit Act aims to regulate the business of insurance. In doing so, BCBSM's Petition errs on the most fundamental level. Because — under *Humana* — the Nonprofit Act does not "invalidate, impair, or supersede" the Nonprofit Act, the question BCBS presents is irrelevant to the outcome of this case. In other words, assuming, *arguendo*, that this Court granted certiorari and determined that Respondents' claim somehow involves policyholders' interests, the McCarran-Ferguson Act still does not apply. Accordingly, BCBS has not established that this case warrants review in this Court and its Petition should be denied.

CONCLUSION

For the foregoing reasons, BCBSM's Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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